TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Houston Orthopedic Surgical

Respondent Name
City of Houston

MFDR Tracking Number
M4-15-3415-01

Carrier's Austin Representative
Box Number 29

MFDR Date Received
June 15, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Sedgwick only paid for one CPT 72132. No payment was made for CPT 72265."

Amount in Dispute: $1,010.33

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…based on the submitted documentation no additional payment is being made at this time. The bill code in dispute is considered inclusive to code 72132 based on NCCI Edits, and is not separately reimbursed."

Response Submitted by: Injury Management Organization, 10235 West Little York Road, Suite 265, Houston, TX 77040

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 9, 2014	72265 -TC	$1,010.33	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 411 – National Correct coding initiative edit – either mutually exclusive of or integral to another service performed on the same day
   - 193 – Original payment decision is being maintained

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code 411 – "National Correct coding initiative edit – either mutually exclusive of or integral to another service performed on the same day." 28 Texas Administrative Code §134.203(b) states, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following:

   (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits;"

   Review of the National Correct Coding Initiatives, www.cms.hhs.gov, finds that CPT code 72265 has a CCI conflict with CPT code 72132 –TC billed on the same day by the requestor. The insurance carrier's denial reason is supported. Additional reimbursement cannot be recommended.

2. Pursuant to Rule 134.203 the service is dispute is not separately payable.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	July 28, 2015 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.